

SELF-HARM LOOKED-AFTER YOUNG PEOPLE IPA

## **Experience of self-harm and its treatment in looked-after young people: An interpretative phenomenological analysis**

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## Abstract

**Objectives:** We report the first Interpretative Phenomenological Analysis examination of self-harm and experience of clinical services in young people in the public care system.

**Methods:** Qualitative interviews with 24 looked-after young people. **Results:** Prevalent themes were 1) Changes in care placement, 2) Feelings of anger, 3) Not wanting/feeling able to talk, 4) Developing coping techniques, 5) Clinical services: A relational mixed bag (subthemes: feeling (i) patronised, not listened to, (ii) nothing being done, (iii) comfortable/able to talk). **Conclusions:** Placement change and anger were highly salient to self-harm in this group and experiences of clinical services depended on individual relationships with clinicians. Implications include increasing compassion in therapeutic relationships, recognizing and managing emotional dysregulation and increasing support during placement changes.

**Key words:** self-harm; interpretative phenomenological analysis (IPA); looked-after young people; adolescence; qualitative methods.

## **Experience of self-harm and its treatment in looked-after young people: An interpretative phenomenological analysis**

Self-harm, defined as any intentional self-injury or self-poisoning regardless of suicidal intent, is highly prevalent in young people (Hawton, Saunders & O'Connor, 2012). Looked-after young people (who are cared for by the public care system in foster or residential homes) are at an even higher risk for self-harm (Taussig, Harpin & Maguire, 2014). Looked-after young people have often experienced childhood trauma such as abuse and neglect, family breakdown and current adversity such as relational difficulties that are risk factors for self-harm (Hawton et al., 2012). High rates of self-harm have been established in this vulnerable group (Harkess-Murphy, Macdonald & Ramsay, 2013; Stanley, Riordan & Alaszewski, 2005), who are also at high risk for suicide, with estimated prevalence rates between two- and four-times those of the general population (Hjern, Vinnerljung & Lindblad, 2004; Katz et al., 2011; Vinnerljung, Hjern & Lindblad, 2006). Given that a history of self-harm is one of the strongest predictors of eventual suicide (Owens, Horrocks & House, 2002), there has been limited research to better understand the circumstances and context of self-harm in looked-after young people, or what supports and services may help. An earlier qualitative interview study of care staff and young people who self-harm in residential care identified elements of helpful support (supportive relationships, non-judgemental attitudes, knowledge of self-harm) and unhelpful support (negative attitudes, poor knowledge, punitive reactions to self-harm), and highlighted the need for further research to inform support for young people who self-harm in care (Piggot, Williams, McLeod & Barton, 2004).

This Interpretative Phenomenological Analysis (IPA) study (to our knowledge, the first undertaken) aims to gain insight into looked-after young people's perceptions and experiences of factors related to self-harm, and of interventions and services received, in order to improve future service provision. We examine how looked-after young people make

sense of the experience of self-harm and resulting supports. IPA is rooted in phenomenology and hermeneutics, so that personal experience and the interpretation of that experience is central. Consequently, IPA can offer novel perspectives on the complex phenomenon of self-harm.

### **Method**

In England, 'looked-after' children and young people are accommodated away from their biological families as a result of a care order (child at significant risk of harm) or the request of their parent(s). Placements include foster, kinship and residential care. In 2013-2014, 68,840 children and young people were looked after by local authorities in England, with the majority (62%) being in receipt of services due to abuse or neglect (Department for Education, 2014). Young people cease to be looked-after at age 18, though most are entitled to leaving care support until 21 years of age (referred to here as 'care leavers'). As this study was part of the first UK project focused on self-harm in looked-after young people, the recruitment strategy was designed to maximise recruitment. As such, participants were recruited from social care services, clinical services and in the community (including care leavers up to age 21).

### ***Participants***

Young people with experience of living in foster care or residential homes (11 to 21 years), and who had self-harmed in the previous six months, were recruited in the East Midlands region (UK). As a result of the multiple-site recruitment strategy, the sample reflected a range of looked-after young people in terms of placement type/status (foster/residential/secure/supported/independent setting, including care-leavers) and level of contact with clinical services. Twenty-four looked-after young people participated (including eight care leavers). Ten were recruited in the community (via a self-harm support

organisation and wider advertising), eight through Child and Adolescent Mental Health Services (CAMHS) and six via social care. Participants were aged between 14 to 21 years ( $M = 16$ ) and four were male.

The majority (75.0%) of participants had lived in two or more care placements; half had lived in between two and five care placements and a quarter reported having six or more placements. Of those with more than one placement, most had lived in different types (e.g. foster care and residential). Thus, the majority of the sample had multiple care placements and in multiple settings. In terms of the looked-after young people's current care placement, ten lived in residential homes, five in foster care and one in supported accommodation. Of the eight care leavers, two lived in foster care homes, one in supported accommodation, two had returned to their biological parents(s) and three lived independently. Most participants (66.7%) reported going into care between the ages of 13 and 15 years with the remainder (29.2%, data missing for one participant) reporting first being accommodated in care between the age of 0 and 9 years.

### ***Semi-structured interviews***

Young people were asked about their experiences and perceptions of the first and most recent episodes of self-harm, repeated self-harm, stopping self-harm and how they viewed the supports and services they received. Example questions are: 'What might stop you from hurting yourself?' or 'Who supports you when you feel distressed?' Background questions relating to self-harm frequency and method, care placement history and mental health diagnoses were also included. The interviews were between 18 and 82 minutes long ( $M = 37$ ). The interviewer (first author) had experience in applying qualitative interviewing and mental health research (but not specifically self-harm). An interview schedule set out questions and prompts as needed, but allowed flexibility for young people to recount their

experience of self-harm in their own way. The interview schedule was created in collaboration with an advisory group of young people who had self-harmed in the past, some of whom also had experience of being in care. The interviews were completed between March 2014 and April 2015 in private at home, university or a volunteer centre.

The study was given ethical approval by the department research ethics committee and the Social Care Research Ethics Committee (as part of the NHS Health Research Authority in England). The participants (and where appropriate, parents, carers and social workers) provided informed consent to participate.

### ***Emotional state visual analogue scale (VAS)***

The participants completed emotional state ratings before and after the interviews (*“how are you feeling”* on a visual analogue scale of 0 to 10) as a way of monitoring participant well-being and distress (Biddle et al., 2013). A referral pathway to support participants was available from a qualified clinician.

### ***Interpretative phenomenological analysis (IPA)***

The interviews were audio-recorded, transcribed and subjected to IPA. Established IPA guidelines were followed (Smith, Flowers & Larkin, 2009). The analysis steps were: 1) familiarization with material through reading and re-reading of the transcript; 2) noting first impressions of the account; 3) exploratory and largely descriptive comments reflecting initial understanding of the content; 4) conceptual/interpretative comments, identifying themes that captured the essential qualities of the account; and 5) organizing themes into a meaningful hierarchy for the account(s) using clusters, super- and subordinate levels. The sample size was large, which influenced the analytic procedure: analysis at the case level moved to an emphasis on the group level, with the aim of establishing key emergent themes for the whole group, thus step 5 was carried out at the group rather than the individual level.

A reflexive log was kept during the analysis to ensure transparency in decision-making. The lead author (who undertook the interviews and analysis) had extensive experience of interviewing young people, but not specifically looked-after young people, and not on the topic of self-harm. She was from a research rather than a clinical or social care training background and did not have detailed knowledge or practical experience of working practices with looked-after young people in either of these settings.

The themes reported were present in at least half of the participants' accounts, and prevalence counts are given in order to demonstrate the validity of the findings in this larger corpus (see Table 1). This is in-line with current IPA quality guidance which advises the need to demonstrate recurrence of theme and density of evidence from the corpus (which may include prevalence counts), particularly in studies with a larger sample size (Smith et al. 2009; Smith, 2011) when trying to balance the idiographic perspective with more generic accounts across the cases (Dickson, Knussen & Flowers, 2007). The themes presented were all strongly evidenced in the corpus and exemplary quotes from multiple participants are given.

## **Results**

Table 1 provides participant characteristics and indicates which themes were present for each participant. The participants had first self-harmed between the ages of 7 and 16 years ( $M = 12$  yrs) and the majority had repeatedly self-harmed for a number of years. Most young people reported self-cutting (96%) and overdosing (63%) as methods of self-harm ever used. Just over half of the sample (53%) reported that they had received a mental health diagnosis from mental health services (including depression and eating disorders). Half the young people had lived in between two and five care placements (25% had one placement, 25% had six or more placements). The mean score on the emotional state VAS at the start of the

interview was 6.77 ( $SD = 2.02$ ) and after the interview was 6.60 ( $SD = 1.83$ ). Participants did not experience a significant change in emotional state during the interview session, as scores were at the positive end of the scale,  $t(23) = 0.65, p = .53$ .

Five major themes were identified: 1) changes in care placement (either as cause or consequence of self-harm); 2) feelings of anger (and turning anger on self); 3) not wanting to talk; not feeling able to talk; 4) developing their own coping techniques to deal with self-harm; and 5) experience of clinical services: a relational mixed bag.

***Changes in care placement are perceived as highly relevant to self-harm (either as cause or consequence) ( $n = 15$ ).***

Many participants reported that they had self-harmed because they had moved care placement or at around the same time as a change in placement: *“When I went back into care, last year, I started cutting”* (ID 20). This young person had returned to foster care after a breakdown in his relationship with his adoptive parents, and described the impact of this move in terms of the loss of important relationships:

*I wasn't living at home, wasn't having much contact with my parents, I was missing school, all my friends were leaving me because I couldn't come out at nine o'clock to come to see them, or meet up after school because I had to get in my taxi and go back to school, go back to my care placements. So, everything sort of was going wrong (ID 20).*

This is important, not least because most of the young people interviewed had gone through at least one transition in care, some of which did not go well from the young person's perspective: *“...they integrated me back [into care] in January this year and it didn't go very well and I ended up walking out and I ended up overdosing on the dinner money that I'd been given”* (ID 17). From this young person's perspective, this incident resulted in a significant



curtailment in ‘privileges’ (not being allowed money, possessions removed from her room, not being allowed out on her own – “*everything had been taken off me*”), leading to further frustration and further self-harm.

In the context of moving to a different placement being experienced as losing control (in terms of independence) and losing support (in terms of significant relationships), self-harm was something, at least, that the young person could still have control over. For example, ID 41 reported that she first self-harmed (cutting, ligature and overdose) after moving to a remote placement due (she believed) to her getting into trouble with the police:

*... they moved me to the middle of nowhere. So, I couldn't see my mum, I couldn't do nothing, couldn't walk out the house without someone being there. So, I couldn't literally have nothing. So, I think that triggered it [self-harm] off* (ID 41)

Similarly, ID 38 reported that she first self-harmed when she moved to a new foster placement and was no longer able to live with her siblings or near her mother:

*... it was just because I'd moved to a different placement and everything was moving so fast, and I just didn't have no control into my life. And everyone was making choices for me and that [self-harm] was my only way of controlling anything. That was my choice to do it or not, and that was the only thing I could control, everything else was controlled by people* (ID 38)

A small number of the young people understood that their placement had been changed as a direct result of their self-harm: “*I moved from my foster placement because I tried hanging myself, and she [foster carer] walked in...she said that she couldn't cope with it any more*” (ID 33); “*And then my foster placement sort of stopped, which was massive, massive, massive shock for me... my foster carer decided she wasn't going to have me anymore*” (ID 34). Thus, self-harm was perceived to be both a consequence of a change in

care arrangements (where a loss of autonomy and/or loss of social support was experienced), and in some cases a reason why a young person lost their placement.

***Feelings of anger (and turning anger on self) (N = 16).***

*I remember one time I'd smashed up the kitchen in my old care home, completely wrecked everything [laugh]. And it was, I think, that was a way of me trying to say, "I don't want to self-harm but I want to get this anger out". (ID 37)*

When participants spoke about feelings associated with self-harm, anger predominated. Self-harm helped to get rid of feelings of anger - *"I just remember how I was really, really angry and then I cut myself, and then all of a sudden I just wasn't angry anymore"* (ID 35), or had been used to replace anger - *"I used to be extremely angry. I used to like punch things, smash things, and everything. And then I just stopped, and went to hurt myself"* (ID 39). In some cases, the acts of self-harm described by participants appeared to be a physical manifestation of anger:

*And things that they were saying... was getting me pumped up, making me angry, making me want to destroy something... I can remember just walking out the front door, going to the side of the house and just f\*\*\*ing smashing the s\*\*t out of the wall. To the point where all my knuckles were bleeding, cut open, blood everywhere, to the point where it physically hurt to even hit the wall or touch the wall with my knuckles. (ID 43)*

Self-harming in anger was also described as having a protective function; by turning anger on themselves in the form of self-harm, they felt they were able to protect others from being hurt by their anger. For example, *"I'm not very good at getting outwardly angry. It's always, I might be feeling angry at someone but I never get angry at another person, I always take my anger out at that person out on myself"* (ID 28).

*I do it [self-harm] for stress as well and pain relief, but then I do it as well so I don't hurt people. Because like, if you look in my record I've hurt quite a lot of people, so like, if you don't cause pain to others you can cause pain to yourself to make you feel a bit better. (ID 41)*

These young people wanted to avoid hurting other people and getting into “bad situations” (ID 40), as they had done in the past. Furthermore, self-harm was regarded by few young people as a quiet or non-disruptive way of expressing their anger, e.g. “...I thought if I just do this [self-harm], then it's, I can release my anger, but it's quiet” (ID 29), “if I made a noise, that would make my mum more violent. And I don't know where the idea came from, but I just thought about using a pair of scissors [to cut] and I remember, it was quiet” (ID 28).

***Not wanting to talk; not feeling able to talk (n = 22).***

*I can find it extremely difficult to talk to people... I couldn't, I don't, I'm finding it very difficult now; but I couldn't talk to people at my worst, I just couldn't talk to; it just wouldn't, it just wasn't happening. I still find it very difficult, but I suppose, if my life's in danger then I have to, otherwise I'm going to die. (ID 34)*

Most young people said they did not want to talk about self-harm and their distress, or felt they were not able to talk about it: “I've never really spoke to anyone about it, like why I do it and why I did it. I just like to be, like keep everything to myself” (ID 38). This young person preferred not to speak to people (for instance, social workers) about self-harm because speaking to people resulted in consequences, “...they will have to] get involved and get someone else involved” (ID 38).

Talking about self-harm was extremely difficult. Some did not want to talk to people because they did not trust anyone - “I can't stand there and talk to someone, because I get really anxious and I can't do it... just don't trust anyone” (ID 41), or they did not want to

burden others – “*because I don’t really like talking to people and bothering people, and it [self-harm] happened*” (ID 42). The vast majority of young people interviewed indicated a reluctance to talk about self-harm, but it was not possible from their accounts to distinguish not *wanting* to talk (perhaps as a result of previous negative reactions from others) and not *being able* to talk about their experiences (for example, in the case of traumatic experiences).

These young people seem to have difficulties in trusting anyone with intimate information about their emotional state. This makes sense considering that most of them have had a life experience with repeated rejections and no consistent reliable adult figure. This unwillingness to talk, however, inevitably had an impact on the potential to seek help when needed.

*My problem is that I don’t branch out to actually get help. Like, all the mental health services here...they always say like “you need to branch [reach] out when you’re feeling distressed, branch out and get help” but I think that’s a problem for me. I think because I’ve never had somebody in my life who I know I can actually rely on, and who will be there. I’ve never felt I can actually trust somebody to reach out, so I don’t. And I know there’s people there, but I don’t seek their help.* (ID 01)

It also has implications for how difficult a young person might find it to interact with professionals in clinical settings. For example, in describing an experience of a clinical appointment, ID 41 explained “*I wasn’t listening; all I thought of was walking out and hitting them. The staff member what were with me, she just spoke and I just sat there [said nothing]*”.

### ***Developing their own coping techniques to deal with self-harm (n = 15).***

When asked about ways of stopping self-harm, participants described how they had managed to develop their own coping techniques. Activities like art, music and going for a

walk reportedly helped them to delay and distract from self-harm: *“I’ve got new things that I’ve learnt, to, how to deal with things like drawing and stuff like that”* (ID 39).

*I do have my strategies of ways not to cut, and who to talk to, and who I can trust in my life and all that... just carry on the way I’m doing now, writing things down, talking...I came up with writing poetry myself really.* (ID 33)

This reliance on self-help seemed more salient to the young people than clinical services, and was generally preferred, *“I prefer to do things independently so try and do my distractions, do my delay tactic, and then like if the thoughts really, really aren’t going, then try and call a friend or something”* (ID 28).

Generally, the young people used positive strategies when trying not to self-harm, but three of them reported that they used smoking as a way of coping with self-harm: *“Smoking was the healthy option, because you don’t die straight away from smoking. It takes years and years and years to die from smoking. But one slit of the vein, and you’re dead”* (ID 25).

***Experience of clinical services: A relational mixed bag (n = 18).***

Although the majority of participants had something to say about their experience of receiving support through Child and Adolescent Mental Health Services (CAMHS), overall these experiences were best categorized as mixed, with a focus on individual interactions with clinicians. The extracts relating to experience of clinical services were mapped onto three subthemes (each being reported by around a third of participants).

***Feeling patronized, not listened to (n = 8).*** When discussing their experience of receiving help through CAMHS, some young people felt patronized by the individual they were seeing: *“...although the lady I was talking to was, she was nice, but she was just incredibly patronizing. And it made me feel a bit like a child, it’s like I’m 18 years old, not*

*eight” (ID 37), “I mean I had CAMHS before, but I found them a bit patronising like” (ID 08).*

*I used to go CAMHS, but I always thought they treated you like a little kid. Yeah, like obviously I’m 16, and they always like show you a piece of paper saying ‘look at this blob, what do you feel today?’ I’m, like, that’s summat what you would do with younger people. (ID 33)*

Some young people also did not feel they were being listened to during their sessions with CAMHS - “...she doesn’t listen to what I say...I don’t know, she twists things I say to...I don’t know how to explain it, but it’s like nothing seems important to her that I say” (ID 27), or that there was a lack of interaction - “And I feel it sometimes when they’re there, they don’t really interact with you, they just sit there with their notebook. They don’t look at you, just sit there with the notebook and pen” (ID 33).

***A sense of nothing being done (n = 8).*** A notable criticism in looked-after young people’s experience of CAMHS was that they did not have a sense that anything was being done to help them. As such, they struggled to see ‘the point’ of their time with CAMHS. For example: “They haven’t done anything. And I don’t know what to expect, because they haven’t, I can’t see any changes. I don’t think when I’m doing something ‘oh, what would CAMHS say?’” (ID 20).

*Every time I see my CAMHS worker I do talk to her about stuff, but, I don’t feel like they do anything about it, she just, we just talk, and then we have another session next week or whatever. It doesn’t help, it’s just annoying because it’s in, you do the same thing every week and every week, and you just talk about it, but nothing happens. (ID 38)*

***Feeling comfortable and able to talk (n = 9).*** However, some positive experiences with CAMHS were also reported, and these were attributed to having a positive relationship

with the professional involved. Particularly, positive experiences related to clinicians making an effort to make the young person feel comfortable and therefore feeling willing to talk.

*“And she went out of her way to make me feel comfortable, and I never felt like I was talking to a professional, she’d always make me feel like she was, like she was really, she was so good” (ID 29).*

*“We actually do, like, activities, so I can express how I feel sometimes, which I find a bit easier. And there’s things that I can fiddle with, things that I can do while I’m there. And she, she doesn’t sit there and stare at you like “I know how you feel”, she’s just realistic. So, I find it quite easy talking to her, and she said, she always said to me “I understand if there are some days you can just sit here and not say a word, I don’t mind.” (ID 08)*

## **Discussion**

To our knowledge, this is the first IPA investigation of self-harm as experienced by looked-after young people. Changes in placement were perceived as highly relevant to their ideation and acts (as a cause but, in some cases, a consequence). Feelings of anger were strongly linked with self-harm, as a way of turning anger upon the self. Young people described not wanting to talk or not feeling able to talk about self-harm, and they had developed their own coping techniques. Experience of clinical services (CAMHS) was varied, with some young people not feeling understood and others feeling supported. These findings build on previous qualitative research that found young people chose to treat their self-inflicted injuries themselves and avoided going to accident and emergency departments due to poor perceived treatment and negative staff attitudes; however, some positive interactions with staff were reported, and these were experienced as sensitive and understanding (Owens, Hansford, Sharkey & Ford, 2016).

### ***Changes in placement***

These findings resonate with previous research which suggests that a lack of placement security and/or permanency predicts mental health difficulties in looked-after children (Tarren-Sweeney, 2008). In relation to this, it is important to note that three-quarters of our participants had experienced at least one change in placement. This is also an important finding, given that frequent relocations can make accessing mental health support more challenging and disrupt continuity of care and development of therapeutic relationships.

Self-harm is more likely to occur when there are changes in care placement. Services need to be aware of this and to anticipate that increased support may be needed at this time (particularly if the young person is moving to a different area of the country). Integration of social care and mental health services, with clear communication, is pertinent during such high-risk transition periods. High quality multi-agency planning around any potential placement move, therefore, appears to be paramount in developing care plans for this group. Evidenced-based training in self-harm should be delivered to all social care staff and carers to help them to understand self-harm as a manifestation of psychological distress, and to respond in a non-judgemental and compassionate way. Research has previously found a tendency for carers to focus on problem behaviours, rather than emotional distress reported by young people to be underlying such behaviours (Beck, 2006). Placement breakdown may also reflect carers' fears because of the risk involved (Callaghan, Young & Richards, 2003).

### ***Feelings of anger***

The salience of feelings of anger and issues of (lack of) control in relation to self-harm have been found in qualitative studies of individuals living in secure accommodation or prison (Brown & Beail, 2009; Mangnall & Yurkovich, 2010). Self-reported reasons for self-harm include affect regulation and expressing anger as self-punishment, with anger identified as a secondary motivation compared to affect regulation (Klonsky, 2009). In this study,



however, looked-after young people reported anger to be a primary motivation for self-harm, and this served more of a protective rather than a punitive function.

The psychological distress described by looked-after young people who self-harm was both driven by anger, and at times, turning this anger on themselves. Interventions and services should thus focus on enhancing adaptive coping strategies whilst reducing emotional distress, such as Dialectical Behavioural Therapy or Mentalization-Based Therapy (Hawton et al., 2015). Foster carers and residential workers require ongoing training in recognizing signs of emotional dysregulation resulting from trauma rather than misconstruing it as directed at them, thus responding negatively, and being more likely to terminate the placement (Allen & Vostanis, 2005). Furthermore, the feelings of anger voiced by looked-after young people need to be understood in relation to their broader interpersonal context and environment; a young person who feels unsupported in an unstable care environment is to be expected to feel anger and distress. This suggests the need for holistic changes at a structural and policy level, to ensure that the promotion of emotional health, the development/protection of supportive relationships and, crucially, that the young person's voice is embedded throughout the system.

### ***Not talking and coping alone***

A reluctance to talk about self-harm has previously been reported by adolescents in qualitative interview studies (Klineberg, Kelly, Stansfeld & Bhui, 2013), which may also be viewed alongside their broader ambivalence in seeking help (Knowles, Townsend & Anderson, 2013; Sayal, Yates, Spears & Stallard, 2014). It is, however, interesting to note that participants in the current study were happy to talk about self-harm with the interviewing researcher. This could be because they perceived there to be no emotional risk in opening up and discussing their self-harm and associated psychological distress (such as not being

understood or initiating the involvement of other professionals). This could also be because the young people viewed the researcher in a neutral position, outside the therapeutic alliance, transference reaction or any emotional investment. Thus, it may be that looked-after young people need reassurance and clarity regarding the consequences of disclosures. This question, however, requires further investigation.

The importance of the development of alternate coping strategies as a component in self-harm cessation has previously been identified in a large qualitative study of university students (Gelinas & Wright, 2013). The same issue arises here. If the goal of intervention or therapy is to cease self-harm (or prevent repetition), young people must be assisted in developing adaptive coping strategies and, importantly, ways to deal with very distressing emotions.

Looked-after young people seem to deal with their self-harm alone; they do not usually talk about self-harm to others and have developed their own coping strategies. This has ramifications for the ease (and willingness) with which looked-after youth can access clinical services, particularly 'talking therapies'. A preference for self-reliance and reluctance to talk is arguably understandable in this group and is an additional barrier to help-seeking. Services may consider making innovative intervention options available, for example by using technologies like computer application (apps) based interventions. There is, however, a substantive difference between not 'wanting' and not 'being able' to share difficult experiences. This is where skilled carers and responsive services are required. Their difficulty in sharing their emotional experiences and thoughts may be understood in the context of the socio-environmental factors such as their difficult and inconsistent past relational experiences resulting in lack of reliability in the present relationships with significant adults. Instead of labelling young people as 'difficult to engage', efforts to engage them should be augmented, and be based on both user and clinician input. One way of achieving this is by involving

young people in the design of services and interventions for self-harm in a meaningful and comprehensive way (rather than tokenistic involvement). This will nevertheless, require significant investment of time and resources in order to optimize the quality of service provision.

***Clinical services: A mixed relational experience***

Overall, this finding was challenging, considering the specialist nature of services involved. This may reflect wide variation of clinical skills in relating to vulnerable and distressed young people, self-harm interventions, goal-setting and, crucially, the complex characteristics of looked-after young people and care systems. Young people reported a mixture of positive and negative experiences with CAMHS that were influenced by interactions with individuals (i.e. patronising versus comforting). The importance of individual interactions should not be underestimated. Especially in case of the complex group like looked-after children, significant time and effort should be invested in the ground work of developing trust and a compassionate therapeutic alliance. Self-harm is one of the most challenging issues that clinicians and carers face (Slee, Arensman, Garnefski & Spinhoven, 2007), but caring and therapeutic relationships are likely to be most easily forged and maintained when they are grounded in compassion (Cole-King, Green, Gask, Hines & Platt, 2013) and are collaborative (Jobes, 2012). Previous qualitative research involving adults and young people attending hospital for self-harm found that interactions with staff shaped future intentions to seek help, depending on whether interactions were accepting versus critical or punitive (Hunter, Chantler, Kapur & Cooper, 2013; Owens et al., 2016). The sense of “nothing being done” by clinical services (also found by Hunter et al., 2013) may be particularly detrimental to levels of engagement with services and should be explored further. The collaborative and regular use of goal based outcomes may be a useful approach (Jobes, 2012). The views of looked-after children and young people regarding their experience of

mental health and social care services should be embedded in service design and transformation as well as individual clinical care as standard practice (Davies & Wright, 2008).

### ***Limitations***

The sample of looked-after young people interviewed were relatively diverse in terms of age, placement type and history and involvement with clinical services. In addition, details regarding the care histories of the looked-after participants, including the circumstances in which they came into to care and experience of maltreatment were not available. The issue of the homogeneity of the sample, and how much is known about their background, is important when considering the theoretical generalisability of our findings. Detailed insights relevant to a particular subset of our sample may have been overlooked (e.g. relevant to the experience of care leavers or young people with shared early childhood experiences). Further in-depth qualitative work with targeted looked-after samples (e.g. a focused clinical sample supported by relevant clinical and social care case note data) could address this gap. The recruitment of looked-after young people as participants was challenging, as previously reported with this group (Heptinstall, 2000; Richardson & Lelliott, 2003). The role of gatekeepers was of particular concern, with reasons for non-participation of looked-after young people often cited as a concern that the individual was not “in a good place”, or that research participation would be damaging to the individual (Murray, 2005). This is important to bear in mind when considering the theoretical generalisability of the present research findings to looked-after young people who self-harm.

Future research in this area should attempt to audit key characteristics of non-participating looked-after young people, in order to explore potential sample biases (e.g. the lack of males in the present study). Furthermore, barriers to recruitment at an individual and

organizational level were often based on a lack of understanding and confidence relating to self-harm. This may suggest specific training is needed on this topic, although training workshops were offered as part of the study recruitment plan and had little uptake – indicating training may only be part of the issue, and further exploration is needed to understand and help address this reluctance.

### ***Conclusions***

Increasing compassion in therapeutic relationships, recognizing and managing emotional dysregulation and other difficult feelings, and enhancing support during placement changes can be addressed within joint care pathways (and with minimal financial implications). Integration of mental health and social care is paramount for this vulnerable population, with development of mutual skills and understanding among caregivers, social workers and mental health practitioners. The importance of listening to looked-after young people who self-harm in a non-judgemental manner is paramount.

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Table 1. Participant characteristics and theme mapping

Superordinate themes present?							
ID	Female/Male	Age	1) Changes in care placement	2) Feelings of anger (turning anger on self)	3) Not wanting to talk; not feeling able to talk	4) Developing their own coping techniques	5) Experience of clinical services: a relational mixed bag
1	Female	20	-	Yes	Yes	Yes	Yes
8	Female	18	-	Yes	Yes	Yes	Yes
17	Female	16	Yes	Yes	-	-	-
20	Male	16	Yes	-	Yes	-	Yes
21	Female	19	-	-	Yes	-	-
23	Female	16	Yes	Yes	Yes	-	Yes
24	Female	17	-	-	Yes	-	Yes
25	Male	16	-	-	Yes	Yes	Yes
27	Female	17	-	Yes	Yes	Yes	Yes
28	Female	21	Yes	Yes	Yes	Yes	Yes
29	Female	17	Yes	Yes	Yes	Yes	Yes

## SELF-HARM LOOKED-AFTER YOUNG PEOPLE IPA

33	Female	16	Yes	-	Yes	Yes	Yes
34	Female	17	Yes	-	Yes	Yes	Yes
35	Female	15	-	Yes	-	-	-
36	Female	16	Yes	Yes	Yes	Yes	Yes
37	Male	18	-	Yes	Yes	Yes	Yes
38	Female	14	Yes	-	Yes	-	Yes
39	Female	18	Yes	Yes	Yes	Yes	Yes
40	Female	14	Yes	Yes	Yes	Yes	-
41	Female	17	Yes	Yes	Yes	Yes	-
42	Female	15	Yes	Yes	Yes	Yes	Yes
43	Male	18	-	Yes	Yes	-	Yes
44	Female	16	Yes	Yes	Yes	Yes	Yes
45	Female	16	Yes	-	Yes	-	-
<b>Frequency of themes</b>			<b>15</b>	<b>16</b>	<b>22</b>	<b>15</b>	<b>18</b>